"STAYING HEALTHY" ASSESSMENT - Children, 4-8 years of age

Child's name (first, last)	Date of birth □□/□□/□□	Sex ☐ Male ☐ Female	Today's date □□/□□/□□	*For Clinical Use*
				Assistance needed:
Your name	Relationship to child ☐ Parent ☐ Guardian ☐ Relative ☐ Friend ☐ Other			**Reading:** ☐ Yes ☐ No
				Interpreter: ☐ Yes ☐ No

You and your child's health care team can work together towards better health. Please answer these questions as best you can. You may check (✓) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child's medical record.

Annual Review Date/Initials

					Interventions Code/Date/Initials
Sample Question and Answer: Does your child go to preschool?	✓ Yes	No	Skip		
	Does Your Home Have:				
1.	A working smoke detector?	Yes	No	Skip	
2.	Water that comes from the faucet hot enough to burn your child?	No	Yes	Skip	
3.	Window guards above the first floor?	Yes	No	Skip	
4.	Cleaning supplies, medicines, and matches in a locked cabinet?	Yes	No	Skip	
5.	Syrup of Ipecac (the medicine used to cause vomiting) and the Poison Control phone number for emergencies?	Yes	No	Skip	
	Does Your Child:				
6.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	Yes	No	Skip	
7.	See the dentist at least once a year?	Yes	No	Skip	
8.	Drink milk or eat yogurt or cheese at least 2 times each day?	Yes	No	Skip	
9.	Eat at least 5 servings of fruits or vegetables each day?	Yes	No	Skip	
10.	Eat only a limited amount of fried or fast foods?	Yes	No	Skip	

For Clinical Use

Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

					For Clinical Use **Interventions Code/Date/Initials**
	Does Your Child:				
11.	Play actively 5 days a week?	No	Yes	Skip	
12.	Need to lose or gain weight?	No	Yes	Skip	
13.	Ever play in the street or unsupervised in the front yard?	Yes	No	Skip	
14.	Always wear a seat belt when riding in a car?	Yes	No	Skip	
15.	Always wear a helmet when riding a bike or skateboard?	No	Yes	Skip	
16.	Spend time at a house or apartment complex with a swimming pool or hot tub?	No	Yes	Skip	
17.	Spend time in a home where a gun is kept?	No	Yes	Skip	
18.	Spend time in a home with anyone who smokes?	No	Yes	Skip	
19.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	
	Has Your Child:				
20.	Ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
21.	Had any problems at home or school?	No	Yes	Skip	
22.	**Do you have other questions or concerns about your child's health?** (Please identify) _____	No	Yes	Skip	

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The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contractedhealth plans, and health care providers.